Minutes 1st Coordination Committee Meeting for Post-Hurricane Reconstruction in Central America and the Caribbean
July 2, 1999

A. Agenda
B. Summary of Recommendations and Discussions
C. CDC slides from presentations
D. Handouts available in hardcopy provided by PAHO at the meeting include:
   - Sample of Disease Surveillance, prevention and control activities in Central America, first semester 1999.
E. List of Attendees

A. Agenda

9:30 a.m.- 9:40 a.m.	**Introduction:** *Mark White, CDC*
9:40 a.m. -10:00 a.m.	**Background:** *PAHO Steve Corber, Daniel Lopez-Acuña, Marlo Libel, Jose Ramiro Cruz*
10:00 a.m.-10:10 a.m.	**Training Programs in Epidemiology and Public Health Interventions Network**: *Jorge Jara*
10:10 a.m.-10:20 a.m.	**USAID and the Hurricane Reconstruction Funds**: *Tim Mahoney, USAID*
10:30 a.m.-10:50 a.m.	**Introduction of the Four Intermediate Results:** *Sharon McDonnell, CDC*
10:50 a.m.-1:00 p.m.	**Breakout Groups:** *Instructions: Sharon McDonnell*
1:00 p.m.-1:45 p.m.	**LUNCH**
1:45 p.m.-2:30 p.m.	**Reports to the Larger Group:** *Breakout Groups*
2:30 p.m.- 3:00 p.m.	**Group Discussion of Specific Implementation Issues:** *Group Discussions*
3:00 p.m.- 4:00 p.m.	**Meeting of Coordination Committee:** *Committee Members*
4:00 p.m.	**ADJOURN**

B. Summary of Recommendations and Discussions

Background

In response to the extensive damage caused by Hurricanes Georges and Mitch in 1998, the Centers for Disease Control and Prevention (CDC) has received approval for funding to assist in reconstruction of public health care systems and implementation of programs to control health problems in the most severely affected countries in collaboration with their respective Ministries of Health (MOHs). This program will be in conjunction with the Pan American Health Organization (PAHO), the Association of Public Health Laboratories (APHL), and Training in Epidemiology and Public Health Interventions Network (TEPHINET). A key part of this effort will be to reestablish effective public health information systems, the capacity to respond to priority health problems through investments in professional training and health program capacity. Ultimately, this renewed capacity will be directed toward establishing specific prevention and control programs selected by the MOH with community input in each country.

The strategic objective for this initiative is to reestablish and sustain capacity for health status assessment and the early detection and effective response to outbreaks and changes in disease patterns. To accomplish this objective, four intermediate results have been identified. They address physical infrastructure, training needs, and processes required for effective public health surveillance, program development, and response capacity for infectious and non-infectious diseases. These intermediate results are described as follows:

1. Rehabilitate disease surveillance systems and use the information for making public health decisions;
2. Increase the availability of trained epidemiologists in the region, and provide training in surveillance, data analysis, and public health practice for health workers at other organizational levels by these epidemiologists;
3. Rehabilitate the infectious disease and environmental health laboratory capacity; and
4. Establish the capacity of MOHs to design and implement community-based disease prevention and control programs.

Results of discussions—and plans:

It was suggested that a presentation of the proposed activities be made at the RESSCA meeting in October 1999. **To meet this goal USAID and CDC will write a letter to the president of RESSCA to request that a technical workshop be attached to the pre-RESSCA technical workgroup.** This letter will need to state that funds from USAID (and CDC) will be available to pay for persons from countries to travel to and attend the workshop. The goal of the two day technical workshop conducted by CDC, PAHO, USAID and TEPHINET would be to show a broad array of activities that might be included in proposed activities and work-plans from countries. In addition, this workshop will provide information about specific types of projects. A concern was raised that this formal committee may not be able to accommodate our goals and activities and that a separate venue may have to be arranged.

A suggested list of topics for the workshop will be made by CDC staff and shared in draft form with USAID, TEPHINET, and PAHO to obtain feedback and additional ideas.

It was agreed that meetings should occur as frequently as needed—for a specific purpose. Communication will be difficult and will require extra efforts to avoid misunderstandings and to make the most of the strengths of each organization. The next meeting will most likely be in August prior to the workshop to finalize the planning.

USAID requested that concerted efforts be made to involve countries and missions as early as possible so they are part of the thinking and planning and able to include their concerns early. Toward this end (as well as increased communication with interested parties overall) the following is planned:

1. CDC will make country visits to describe the project and discuss country needs. This will be arranged with missions and PAHO offices. Missions so far have requested that they be responsible for meeting planning and thus, will arrange in-country meetings.
2. USAID will share the proposal with missions. CDC will have it translated. PAHO will make available a more detailed plan of their activities for sharing with the larger CDC proposal.
3. A web site with the proposal (English and Spanish), timelines, and other associated materials will be investigated as a possible information source for interested parties.

Refer to the timelines and proposed process for the development of the work-plan (attachment). It is suggested that team size be flexible. Currently there are many requests to participate. CDC will request that staff in PAHO, CDC, APHL, TEPHINET and possibly other agencies inform them of their interest in timing, sites and availability.

The assessment tool will be developed by CDC staff Dr.'s Paul Stehr-Green and Peter Nsubuga with technical input by multiple CDC staff, PAHO, CSTE (Council of State and Territorial Epidemiologists), APHL, and others. This tool will be developed based on the objectives of the assessments and after reviews the WHO/CDC/AFRO surveillance system tool, the CDC surveillance evaluation materials, Data for Decision-Making materials, the assessment initiative tools and priority setting materials of SMDP and PAHO. Other background materials will include APEX and the evaluation tool for FETPs. This tool will include a mix of quantitative and qualitative information that will be used in country assessments to help national and international staff conduct priority setting and develop a proposal for funds based on the four IRs.

PAHO will develop a more detailed proposal for the $2 million that will be submitted to CDC and be substituted for the current annex in the larger CDC document. This will be coming within the next week. PAHO has proposed activities that were integrated into an annex within the current CDC document to USAID with general activity areas.

Assessment teams will be planned over the next few weeks. These will be set up based on USAID missions' input and will likely coordinate PAHO, CDC, APHL and others. A mix of expertise, Spanish fluency and a person to act as project "champion" for the review committee will be necessary.

The project should take necessary steps to promote epidemiology and laboratory personnel interaction to further encourage in-country collaborations in these areas. It is recommended that onsite assessments combine epi and lab components, rather than through separate assessment trips.

CDC will mail to PAHO the FETP evaluation materials for Dr. Daniel Lopez-Acuña, Director, Division of Health Systems and Services Development, PAHO.

CDC will send notes of meeting in draft to attendees and invitees for review and information. Broader distribution to be discussed.

C. CDC Presentations at the Coordination Meeting

Philosophy of the Project

1. Sustainability:
   a. Short-term funds (2-3 years) for long-term improvements.
   b. National involvement in every step
   c. National investment early on

2. The project is:
   -Primarily directed towards capacity development
   -Menu of opportunities and program elements
   -Based on a defined process
   -Linked (each part links together)
   -Related to the functioning of a health program and ultimately health outcomes

3. Built upon strengths in existing projects

4. Collaboration

5. Regional approach-- Desirable that country experiences gained be available to others for learning and to enhance resources.

Intermediate Results

IR1: Health information and disease surveillance systems rehabilitation with information use for public health decisions

IR2: Increased availability of field epidemiologists (public health practitioners) in the region and training of other levels of health workers by these epidemiologists

IR3: Infectious disease and environmental health laboratory capacity developed

IR4: Capacity of Ministries of Health to design and implement community based disease prevention and control programs

Regional Activities with partners:
PAHO
TEPHINET

Specific Intermediate Objectives and Outputs

IR1: Health information and disease surveillance systems rehabilitation with information use for public health decisions

Outputs:

- Improved health information system or information system function (detection, reporting, analysis, dissemination, planning).
- Regional communication training and bulletins
- National information dissemination
- Early warning system plan
- Understand key problem areas that FETP trainees will be involved in over 3 years.
- Through priority setting process select National health problem to focus on.

IR2: Increased availability of field epidemiologists (public health practitioners) in the region and training of other levels of health workers by these epidemiologists

Outputs:

- 38 Field Epidemiologists (public health practitioners) from 5-7 countries.
- 2 regional sites that will continue to train over time with link to country programs.
- Field epidemiologists train clinical and public health workers on public health and epidemiology. Often approximately 50-100 trainees per year
- Information systems
- See competencies

IR3: Infectious disease and environmental health laboratory capacity developed

Outputs:

- Plans for regional and national laboratory capacity
- Training in country of laboratorians
- International Training of laboratorians
- Equipment
- Proficiency testing and standardization

IR4: Capacity of Ministries of Health to design and implement community based disease prevention and control programs

- based on health information systems reviews select at least one health problem in the country to target.
- Define and implement improvements in the health program to deliver the services (process improvements)
- Define the means to measure health impact over 5 years (health outcomes).
- Using FETP and DDM project staff to involve the community in the prevention and control activities.
- Regional sharing of lessons learned.

Regional Activities with partners:
PAHO
TEPHINET

Both partners will provide more detailed proposals and work plans.

Process for Development of Work-Plan and Beginning Implementation

1. Make assessment tools and refine/field test. Plan workshop and announce.

2. Workshop in Central America in late August or early September possibly coincident with (pre-RESSCA).
    - Show range of activities mentioned in IRs
    - Show examples (region and beyond)
    - Explain necessary inputs and activities at national level (staff, funds, and buildings)

3. Nationals return home and begin planning for visits and CDC staff trained and ready for assessments

4. Teams come to countries to do assessments and write a specific proposal including all IRs

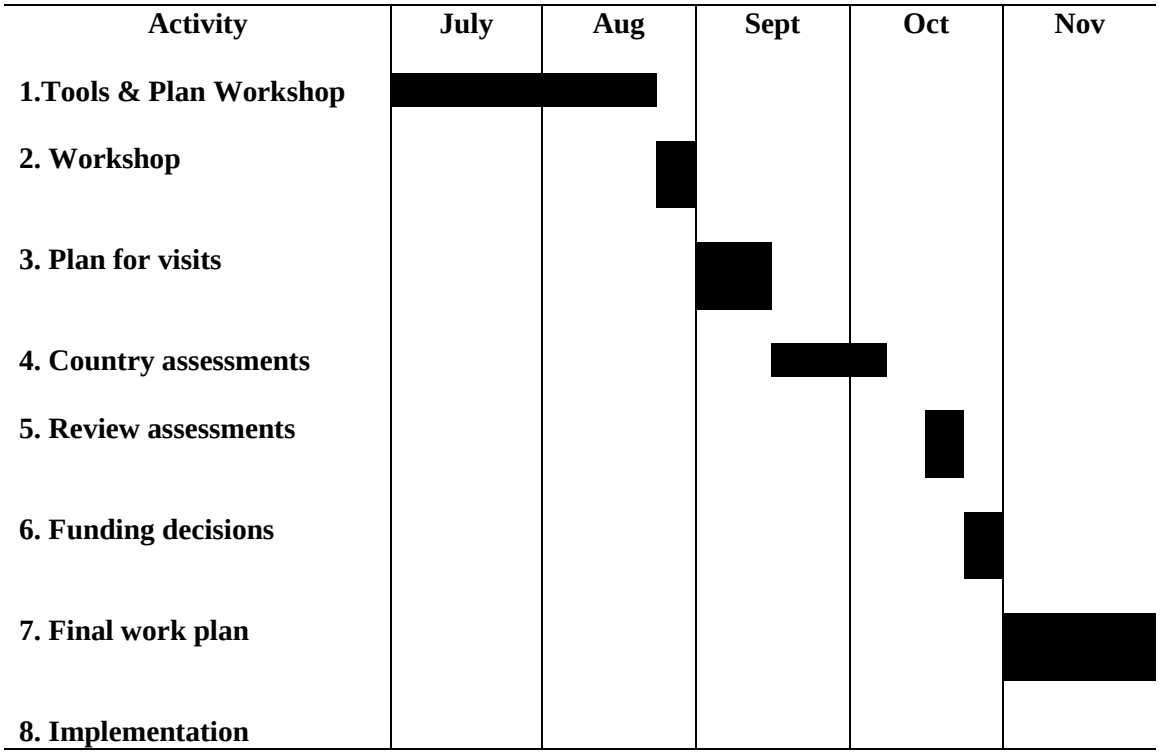
5. Team returns to Atlanta and (lead member = proposal champion)—presents proposal in larger meeting for consideration.

6. Decisions made re funded elements and sites for FETPs.

7. Work-plan to USAID (120 days after IAA).

8. Implementation – specific follow-up assessments, staff, timing, etc., depends on specific activities selected.

Timeline for Initial Activities, July – November, 1999



D. List of Attendees

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